Regal Healthcare Properties Limited

Brooke House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 29 August and 7 September 2017. The first inspection visit was unannounced. We told the registered manager when we would return for our second visit.

Brooke House provides accommodation and support for up to 35 people who may be living with dementia, mental health support needs or with physical disabilities. At the time of this inspection there were 33 people living in the home. The service has an older unit in the main house, arranged over two floors with lift access between. The Brookefields unit is adjacent to the main home, is purpose built and on one floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was recently registered with CQC, completing the process in April 2017.

At our last inspection in August 2016. we did not identify any breaches of regulations. However, the safety and effectiveness of the service needed to improve. This included improvements in the way some medicines were managed, monitoring of pressure areas and in the timely completion of staff training. This included training for staff to understand their legal obligations when supporting people who might not be able to make specific, informed decisions.

At this inspection, we found that improvements had been made in the areas we highlighted last time. Some further improvement was needed to ensure the service people received was always as safe as it should be.

There was a new, electronic system for managing medicines. This tracked who had administered medicines, when, and provided a system for auditing, with daily reports. The registered manager could show they took prompt action to address any anomalies identified in the daily reports. The system was still bedding in but indicated improvements in the safe management of medicines. A concern was raised with us before our inspection, that sometimes people were without medicines because staff had not ordered it in a timely way. We found that the new system alerted staff to the need to reorder items and that people were unlikely to be left without essential medicines.

There were enough staff to support people safely. Robust recruitment processes and checks continued to protect people from the employment of staff not suitable to work in care. Staff were clear about their obligations to report any concerns should they suspect that people might be at risk of harm or abuse and people said they felt well treated by staff. However, a recent visit by the safeguarding and quality assurance team, highlighted two situations of concern. They considered that the registered manager should have shared these concerns with the local authority safeguarding team. The management team had taken action in relation to the safeguarding and quality assurance visit both to investigate and learn from the feedback they received.

During our inspection, we found a further example of an incident that should have triggered prompt discussion with the safeguarding team and further exploration. Between our two inspection visits, the management team acted on the concern that we raised. The registered manager and deputy manager had enrolled on further training specifically for the management of safeguarding concerns and possible abuse. They anticipated this would improve their awareness of issues that might indicate concern and require advice from safeguarding specialists.

Risks to people's safety and welfare were assessed and staff had guidance about minimising these. They were able to tell us what they did to promote people's safety and about their training to understand their obligations. The registered manager had made improvements to the timeliness with which staff completed their expected training. She had also sourced additional training for staff to help them in supporting people at risk of developing pressure ulcers. Staff felt this had improved their awareness of what to look for to ensure people's wellbeing and when to seek additional advice.

Staff were better prepared through training and additional guidance to understand their legal obligations when they supported people who may not be able to make decisions for themselves. The registered manager had also taken action to improve the day-to-day management of shifts by senior staff. This included providing clearer information about expectations and additional training in leadership.

People had a choice of enough to eat and drink to meet their needs. Staff monitored people at risk of not eating or drinking enough so they could seek professional advice about this aspect of people's health when they needed to. They also ensured people could access advice from other health professionals, such as their doctor and the district nursing team.

Staff had developed warm and caring relationships with people. We saw an example of people's dignity not being fully upheld during one mealtime. However, the registered manager took prompt action to improve people's experiences so this was not repeated when we checked again. She, and the operations manager, also agreed further action that would make sure staff could position themselves better and more easily, when the helped people to eat.

Staff understood people's needs and preferences, so that they could engage with people about what was important to them. They took people's hobbies and interests into account when they were both conversing with them or supporting people with activities.

People, with support from their relatives if they needed it, were given the opportunity to express their views and make decisions about their care. They were confident that, if they had concerns or complaints about their care, the registered manager would deal with them.

The registered manager and the provider had systems in place to ensure they monitored and checked the safety of the service, taking people's views into account. The registered manager and operations manager responded quickly and constructively to the issues that we raised. Their internal monitoring systems also showed where they identified improvements were needed and the action taken. This included arranging additional management training and support, as the registered manager was relatively new to her role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management team had not always fully recognised concerns that people were at risk of possible harm or abuse and reported it accordingly. The records about people's daily care were not always sufficiently detailed to support the management team in identifying concerns about possible harm or abuse.

Risks to people's safety and wellbeing were assessed with guidance for staff about how to minimise them.

There were enough staff to support people safely and recruitment practices contributed to protecting people from the employment of staff who were unsuitable to work in care.

Medicines were managed safely so that people received them as the prescriber intended and audit systems meant possible errors were identified and addressed promptly.

Is the service effective?

Good

The service was effective.

Staff completed training in a more timely way than at our last inspection, so that they were competent to support people.

Staff had an improved understanding of how to support people who may not be able to give informed consent to their care and of their legal obligations when offering support.

People had a choice of enough food and drink to meet their needs.

Staff supported people to access advice about their health and welfare and acted upon it to ensure they promoted people's wellbeing.

Is the service caring?

Good

The service was caring.

The management team took prompt action following our first inspection visit, to ensure people were supported in a dignified way when they were eating their meals.

Staff promoted people's dignity and privacy when they delivered care and encouraged people to maintain as much independence as possible.

Staff had developed warm and compassionate relationships with people and supported them to make choices about their care.

Is the service responsive?

Good

The service was responsive.

Staff delivered care to people in a way that addressed their individual needs and took into account their preferences.

People and their relatives were confident that their concerns and complaints were properly listened to and addressed.

Is the service well-led?

Good

The service was well-led.

People, their relatives and staff, were confident that the registered manager was approachable and took account of their views and opinions.

Where improvements were needed, the management team took prompt action to accept and address shortfalls. The provider's representatives were exploring additional management development training to enhance this further and drive improvements.

Brooke House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 August and 7 September 2017. The first day was unannounced. We told the registered manager when we were returning for the second day. It was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the service. This included the history of the service, any concerns raised with us and information shared with us by other agencies such as the local authority or safeguarding team. We also reviewed the information contained in notifications. The providers and managers of care services are required by law to notify us about specific events and incidents happening within the service.

During our inspection, we spoke with seven people using the service and living in the main part of the home. We also spoke with six relatives. In the Brookefield Unit, where people were living with dementia, we observed how people were supported in the lounge and dining area. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five members of the care team, including the activities coordinator, and a member of ancillary staff. We also spoke with the registered manager, deputy manager, and the provider's operations manager and service quality manager.

We reviewed the care records for six people and the arrangements for managing their medicines. We checked the recruitment records for three staff and training records for the staff team. We also inspected a sample of records to do with the quality and safety of the service, such as maintenance and safety checks.

After our inspection visit, we asked the registered manager to supply some supplementary information about one person's care. This was supplied promptly when we asked for it.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this service in August 2016, we found that the safety of the service needed to improve. This included the way that risks were managed, how staff were deployed, and some aspects of medicines management. This did not amount to a breach of regulations but did raise concerns for consistent and safe support.

At this inspection, we found improvements in these areas. People felt that there were enough staff to support them safely. One person told us, "The staff are very busy." However, they went on to say that people did not have to wait long for assistance if they needed it. Another person commented, "I think the staff are too busy, it's nice to be helped but there is a limit to what they can do." However, they did not feel unsafe because of staffing levels.

A health professional commented to us that there were occasions when the service might be short staffed because of last minute changes. They told us that they felt this did not amount to unsafe staffing. They said they felt staff still delivered care correctly and were conscientious about doing so, including when they were short staffed. We observed that staff attended to people's needs promptly and that people were not left waiting for any essential assistance they needed. Staff responded quickly to people using their call bells. We also saw that staff intervened promptly if people attempted to move independently or without their mobility aids and were not safe to do so.

Staff spoken with felt that there were enough of them to support people safely. For example, one staff member told us, "There are plenty of staff, the manager is very helpful. She always comes over to offer support." Another staff member told us, "There is the right amount of staff." We received conflicting views about how often the registered manager helped out, to boost staffing levels at peak times of day. A relative commented that they had not seen the registered manager help out very often, including with support in the dining room. A staff member also said that it was not usual to see the registered manager help at mealtimes but they had done so during our inspection.

However, this contrasted with what other staff told us and what we saw. When we arrived for our first inspection visit, staff did not know we were coming. When the staff member who answered the door went to find the registered manager, she was helping with people's breakfasts. A staff member told us they could also secure advice about people's safety from either the registered manager or deputy manager. They told us, "One or other of them is on call and we always get a response." We also noted that the staff member designated to provide activities offered support to people during the busy lunchtime period.

We reviewed the systems for managing medicines and these showed that people received their medicines as intended by the prescriber. Four people we asked told us that staff made sure they had their medicines regularly and that they had not missed any. They told us that staff explained to them what their medicines were and what they were for.

A staff member gave us a clear description of how they managed medicines and confirmed they had training

to do this safely. Training records supported this. They had received additional training in using the provider's new system and staff had their competence re-assessed from time to time. We noted that staff held keys to treatment rooms and medicines trolleys securely to ensure medicines were stored safely.

The service had only recently transferred their medicine management arrangements to an electronic system, which was still bedding in and will need further review at the next inspection. The management team considered that the new system would help minimise the risk of errors and flag up promptly whether staff had made any. Each senior staff member had his or her own password for logging into the system. This made it clear who was accountable for administering each medicine. They scanned a barcode on people's medicines when they were administering them, and the electronic system recorded who was responsible and when people received their medicines.

The system also gave warning so that doses of medicines could not be given too close together. It provided reminders when staff needed to order fresh supplies of medicines to ensure people did not run out.

We reviewed how the system worked to audit the safety of medicines management. The registered manager showed us how they and their line managers received a daily report. Where there were exceptions, such as a missed medicine, the electronic records identified this. In addition to this, there was a rolling programme of checks "in house" to ensure staff managed medicines appropriately. This enabled the management team to address any errors or shortfalls promptly and records showed that they had done so.

Staff recognised the importance of reporting suspicions of possible harm or abuse. However, we were concerned about whether some issues were fully recognised as potential safeguarding matters and robustly addressed. The service needed to make some improvements to people's safety to ensure they responded appropriately to safeguarding concerns.

We received feedback from a member of the local authority's quality assurance team and a safeguarding practitioner in the clinical commissioning group. This was following their visit to the service to follow up some concerns. At their visit, they had identified two incidents the management team should have reported to the local safeguarding team. We found a further incident, the full nature of which and possible cause was unexplored. The management team should have reported to the safeguarding team.

The registered manager explained to us what might have caused the injury. However, daily records lacked sufficient detail to support this possible cause. The registered manager should have informed the local authority's safeguarding team and notified the Care Quality Commission (CQC) about this incident. This could have secured some support at an early stage to support an investigation into the unexplained injury. We did note however, that staff had updated the person's care plan to reflect how their injury was to be treated in line with a family member's views. They had also secured advice from health professionals, so they had taken action once it was found.

During our inspection, a relative expressed some concerns that staff had not assisted their family member to wash and dress in preparation for a planned outing. They felt staff may have forgotten to do so and the person was still sitting in their room waiting for staff to help. When we reviewed our information after the inspection visits, we followed this up. The registered manager told us that the person was able to make decisions about whether they wanted to get up or not, and would sometimes choose not to do so. However, records for that day did not show that the person had declined support but suggested staff had not offered it for most of the morning.

The records were not sufficiently clear in either of these two cases to enable the registered manager to

pursue concerns robustly about whether there was abuse or neglect. We know from their report, that the local authority's quality assurance officer also voiced some concerns about record keeping. They felt records did not always contain enough detail for the manager to investigate concerns properly. We raised our concerns with the registered manager who acknowledged the lack of detail. They explained to us how they were following this up with the staff team and monitoring the system closely until they were satisfied staff used it as well as they should.

The safeguarding practitioner and quality assurance officer told us they advised the management team to attend formal training about managing allegations of abuse. They told us that both the registered manager and deputy manager had enrolled on the first available course, due shortly after our inspection. This should help to increase their awareness of how to deal robustly with similar situations in future.

The registered manager confirmed how they had investigated a previous concern about a risk of harm and taken action with the staff involved. We know from information about how the registered manager handled another previous incident, they had reinforced with staff the importance of coming forward with any concerns they had.

People told us that they had no concerns about the way staff treated them. A relative told us, "Staff do all check in on [family member]. I believe she is safe. Definitely. She is very relaxed." They felt that they would know if something was wrong or distressed their family member. Staff gave us examples of potentially abusive situations and were clear about their obligations to report concerns. We asked what a staff member would do if management did not respond and they told us, "I would contact CQC, social services safeguarding team and if necessary the police."

The provider's recruitment processes were robust in ensuring applicants completed appropriate checks before they were confirmed in post. This included taking up references, checking employment histories and completing enhanced checks on the background of potential staff. These practices contributed to protecting people from the appointment of staff who were not suitable to work in care services.

Staff identified and assessed risks to people's safety. Staff understood the importance of these assessments in helping them deliver safe care. One staff member told us, "We have to go through the risk assessments and care plans. You have to know the person before you work with them. Every person is different, with different needs." Another staff member said, "Everyone has risk assessments which guide us how to support their individual needs, for example slips, trips and falls."

Assessments took into account a range of risks such as for mental and physical health, falls, nutrition and for the prevention of pressure ulcers. The information we reviewed contained guidance for staff to follow to manage and mitigate these risks. For example, where people required pressure-relieving equipment to maintain their skin integrity, staff ensured they transferred cushions with the person when they moved.

People told us that they felt staff supported them safely when they needed assistance to move and when staff used equipment to assist them. We observed that staff used equipment in a safe way if people needed it to transfer between chairs and wheelchairs. Staff told us they had training to use such equipment properly and in safe moving and handling techniques. Training records supported this. We observed that staff took time to ensure they fastened slings properly and explained to people what needed to happen to move them safely. There were arrangements to ensure proper servicing and maintenance of equipment used to support people with moving to ensure this remained safe to use.

Staff were aware of the risks to some people of not eating and drinking enough. The management team

used the Malnutrition Universal Screening Tool (MUST). This is an appropriate tool designed specifically for this purpose. It supports proper assessment of risk and prompts staff to intervene when risks changed. Staff understood the risks of people choking and were able to describe that they needed to do to minimise these. They understood how to position people and assist them in a way that managed these risks. Both the care team and catering staff knew who needed their food prepared in a particular way, for example mashed or pureed, to minimise risks.

One person's records we reviewed set out the likely triggers for them to become anxious and distressed. Staff were able to explain how they supported the person to minimise risks and the information they gave us was consistent with their care records.

People had personal emergency evacuation plans in their care records to explain how staff needed to support them safely in the event of an emergency evacuation of the building. There was a 'traffic light' summary of the information setting out briefly the level of support each person needed. This was, near the main office and fire detection panel for use in an emergency. There were also contingency plans for staff to follow, setting out the action to take if an emergency or untoward event affected the safe running of the service.

Accidents and incidents were reviewed to see whether there was any action to be taken to reduce the likelihood of recurrence and to update risk assessments if needed. This contributed to promoting people's safety.

Good

Is the service effective?

Our findings

At our last inspection of this service in August 2016, we found that mealtimes were sometimes disorganised with people not receiving consistent support. Staff did not complete their electronic training in a timely manner when they needed to. The staff team was not always well prepared, through training, to support people who might not be able to make informed decisions for themselves. These issues did not amount to a breach of regulations, but the effectiveness of the service required improvement. At this inspection, we found that the registered manager had taken action and people received an effective service.

People, their relatives and a health professional told us they felt that staff were trained and competent to meet their needs. For example, one relative said, "The best thing about this place is the staff." We found that training arrangements had improved. This was for both basic training and timely completion of induction, and where additional training needs were identified as of benefit in improving care for people. Records showed that there were improvements in the timely completion of this training for the first time, and renewing it when necessary.

Staff spoken with told us that they felt they had training to deliver care competently. One new staff member told us about shadowing shifts. They said that these were sufficient for them to feel confident about offering support to people. They told us that experienced staff had checked to ensure they were competent to use equipment for assisting people to move and transfer. They also told us about the information they were given relating to people's specific needs and what they should do to support them.

We noted that the management team identified and sourced additional training for staff where they found an area of need. The information we reviewed showed that this had included recent training in tissue viability. A staff member told us this had improved staff awareness of what to look for and they would seek advice more quickly. The provider of the service had also arranged for members of their management team to complete additional training. This was in best practice for supporting people living with dementia as recognised by Sterling University.

The management team had recognised that senior staff, who led shifts on a day-to-day basis, would benefit from additional training in their roles and responsibilities. The provider's management team arranged for senior care staff to start diploma training in team leading and management. Staff told us they felt well supported by the management team and received supervision to discuss their work and development needs. The registered manager maintained a schedule and monitored when staff were due to receive supervision so that they received the right support and she could take action if the expected frequency slipped.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records confirmed that staff had completed training in the MCA. Staff spoken with had an improved understanding of this topic. For example, staff confirmed that people supported to make decisions concerning their day-to-day support by using communication techniques individual to the person. One staff member told us, "You must assume everyone has [mental] capacity unless proved otherwise." Another staff member said, "We can't just restrict people. There are processes to go through."

We observed staff seeking consent to deliver support to people. For example, one staff member asked a person whether they wanted their hair brushing. Another person asked for staff assistance to be taken to the toilet. The staff member asked whether the person would like to use their wheelchair or walking frame to get there. Other people were asked whether they needed any assistance to cut up their food before staff intervened. In the Brookefields Unit, staff asked people if it was all right to assist them to eat their meals.

We checked people's care records to see how the MCA was taken into consideration. We found that these reflected people's capacity to make specific decisions. They showed that, if a person lacked capacity to make specific decisions about their care, their best interests were taken into account. We noted that these considerations related to one person's best interests in relation to taking their medicines. They were assessed, with other professionals, as not understanding the implications for their health if they refused and, if they did so, it was in their best interests to administer medicines covertly. This limitation on their rights was also appropriately considered in their DoLS application.

The registered manager had copies of "Lasting Power of Attorney" (LPA) authorisations where these were in place. These showed were another person had legal authority to make decisions about health and welfare for individuals who lacked capacity to make some decisions. We discussed with the registered manager that they might need to consider decisions made by those with an LPA, as they were obliged to act in the person's best interests. This was so they could seek additional advice and wider consultation with health professionals if there were any conflicts or concerns.

The registered manager knew when they needed to make DoLS applications to promote people's safety. Records showed the involvement of relatives and multi-disciplinary teams to help determine the action needed to ensure people's safety in the least restrictive way. For most people, the outcomes of these were still awaited.

People were supported to have a choice of enough food and drink to meet their needs. One person told us, "I like the food here." A relative commented, "[Family member] hated the food initially, but it was the tuna bake that she liked which encouraged her to eat, she enjoys the food here now." Another relative told us, "[Family member] had decided not to eat but she's put on weight and looks well now… The food is lovely. She loves fish and when she was low weight, we discussed her likes so they've increased her food intake." We noted that people's likes and dislikes for food were recorded in their care plans so that staff could tempt them with their favourite foods if necessary.

The chef catered for people's dietary needs including providing meals suitable for people who needed a soft diet or who lived with diabetes. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

Staff understood how to support people who received their food and fluids through percutaneous endoscopic gastrostomy (PEG) tubes. These involve placement of a tube through a person's abdominal wall into their stomach. They are used for people to receive nutritional liquids, fluids and medicines when people can no longer take this orally for any reason. Staff were knowledgeable about the management of these and gave us information that was consistent with their plans of care. This included information about how they positioned people, the action they took to check the PEG tubes and how they supported people with their nutritional regime.

In the main dining room in Brooke House, we saw the menu for lunch displayed for people so they could make their selection. Staff told people what was on offer if they were not able to see the menu for any reason. We observed that staff explained to one person what was on offer while they were preparing to assist them from the lounge to the dining room. When the person did not understand what "au gratin" meant, the staff member explained it clearly, so that they could make their choice.

People were able to help themselves to vegetables and asked if they wanted gravy or not. There were condiments and napkins available to people. In the Brookefields Unit staff explained to people what was on offer. There was some variable practice in showing people sample meals from which to choose, but staff did so for those people who found it difficult to make a choice. We noted that plate guards were available if people needed this to help them eat independently.

We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas. In the Brooke House dining room, we saw that some people had drinks placed towards the centre of the table. This made it difficult for them to reach without assistance. This could improve so that people did not need to ask staff for help and could drink when they wished to during their meal. There were 'snack baskets' in each unit with fruit, crisps and biscuits available to people if they were hungry. Staff monitored people's food and fluid intake to ensure they were eating and drinking enough.

We noted that, where one person had lost weight, staff monitored this more closely. They also sought a dietician's advice about maintaining this aspect of the person's health. In addition to dietary advice, staff also supported people to access advice and treatment from health professionals such as their GP, chiropodist, optician or district nurse. We noted that an optician attended the home during part of our inspection, to test some people's eyesight.

We spoke with a district nurse about how staff interacted with them. They told us that staff were good at referring people promptly for advice or treatment if their condition changed. They said that staff were usually good at acting on the advice they gave about a person's treatment and following this through.

We found that, if needed, staff would support people to attend their hospital appointments. Each person had "transfer to hospital" information providing essential details about a person should they need to be admitted to hospital. This helped to make sure that hospital staff would have information about people's general health, how they communicated and any specific wishes regarding their healthcare.

Good

Is the service caring?

Our findings

At our last inspection of this service in August 2016, we found that the service was caring. On our first visit for this inspection, we noted some isolated examples of staff compromising people's dignity. The registered manager rectified this before we completed our inspection visits and people continued to receive a caring service.

During the first inspection visit in the Brookefield Unit, we saw staff standing over people or beside people while supporting people to eat and drink. This resulted in people having to arch their neck up to reach their food and drink. There was not very much conversation between staff and people during lunch and there were missed opportunities for stimulating interactions. At the close of our first inspection visit, we shared our views with the management team.

During our second inspection visit, we saw that this was improved. We noted that staff engaged with people in discussing their meals, and made conversation with them, for example about the weather or their families. Our observations showed that they assisted people at their own pace. There were no examples of poor interactions between staff and people using the service during our observation. None of the people using the dining room showed any signs of being ill at ease or distressed during their meal.

Staff made sure that they sat alongside the people they were assisting. On one occasion, this meant a staff member fetching a chair from a nearby room, but they did so immediately. The operations manager and registered manager agreed that they could easily source smaller, possibly folding seating, for staff to use when they supported people with their meals. This would take up less space when staff sat alongside people at dining tables and reduce any temptation to stand while they supported people.

We noted that one staff member encouraged a person by assisting them when they needed it, but also reminding and encouraging them to do what they could for themselves. This helped to promote the person's independence with their agreement and as far as practicable. In the main dining room, we observed that staff chatted with people during their meals. They used it as an opportunity to encourage reminiscence, talking to people about their holidays and places they had visited. Four people using three other separate tables did not have the same level of engagement during the meal. However, after they had finished eating, staff did check with them how they were and what they thought about their food. They listened to people's views and in one case, undertook to follow up a suggestion with the chef.

Before we carried out our inspection visits, we received concerns that people's dignity was sometimes compromised by laundry arrangements. This included that clothes were kept in the laundry for communal use when their owners were not identified or no longer living in the home. We discussed arrangements with a new member of ancillary staff who was able to explain how clothes were labelled and how they managed arrangements to return them to the right people. We found no concerns for people's dignity in relation to laundry practices. The quality assurance team were aware of this when their officer visited and found no evidence of concerns.

We noted that an optician's visit did present some disruption for two people who were not directly involved in the process. They were trying to watch television but the person receiving an eye test was in the same room. The optician closed the curtains to make the room dark so that they could carry out the test and turned the lights on and off several times. This made it difficult for the two people not having the eye test to enjoy the environment. Consideration could be given to using a different location or people's own rooms to enhance people's dignity on such occasions.

Staff were able to describe confidently to us how they promoted people's privacy and dignity when they delivered personal care. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. One member of staff told us they always covered the lower part of a person if they were washing the top. This contributed to promoting people's dignity. A relative told us how their family member was asked if they minded receiving support with personal care from a male member of staff. They told us that the person did not mind about this but felt it would help people to feel more at ease.

One person told us, "They [staff] are kind and caring." Another person said, "They [staff] treat me with respect … they don't know me yet but it's nice to talk to them." Where people were living with dementia and not able to express their views very clearly, we observed interactions with staff that were friendly, caring and thoughtful. A relative said, "The staff are nice, kind and very patient. They give [family member] time… I have never had any issues about the way I have heard staff speak with anyone."

Staff took time to establish people's views and what they were trying to say. For example, we saw that one person found it hard to find the right words, so staff sat patiently and used their experience of the person to communicate. Staff interacted well with people, touching, reassuring and complimenting people as they passed. They also checked that people were comfortable, such as whether they wanted a blanket or wanted windows open or closed.

We observed that staff intervened promptly when people became distressed or anxious to offer both comfort and reassurance or to resolve problems. We noted that one person's decision to sit at a particular table did present difficulties after they had eaten. A walking frame obstructed their way when they wanted to leave the dining room. Staff intervened promptly to resolve the issue so that it did not escalate. Staff could possibly discuss people's preferred seating positions with them to pre-empt similar problems in future. We also noted that one person was upset about some personal, family news. We saw that the registered manager spoke with the person with empathy and respect about their concerns. This relieved some of the person's anxiety and distress.

We saw that staff explained to people what they needed to do before providing support, and offered reassurance. For example, when they assisted one person with the hoist, they explained how they needed the person to move and hold onto the equipment. Staff involved checked with the person whether they were comfortable and ready for lifting. We noted only one isolated exception when staff moved a person in their wheelchair without first checking if it was all right to do so. A member of staff told us they felt, "It is important to communicate with people what you're doing."

Some people living with dementia were not able to tell us clearly about how they were involved in making decisions and choices about their care. However, we found that care plans contained people's preferences. Staff had information about people's earlier lives, their likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or

sad times. This encouraged staff to see what was important to the person and how best to support them. A staff member told us, "We have information about people's backgrounds. It means we can connect with them better. We can always gather more information from families if people can't tell us."

With the exception of one relative, others felt that they were involved in supporting people to express their choices and make decisions about care. One told us, "I haven't had any meeting or updates regarding the care plan." This conflicted with the views of others who were satisfied that people were involved and could make choices. For example, a relative told us, "We did discuss the care plan when she arrived. The care home manager asked everything in quite a lot of detail and the manager then gave me a copy." Another relative said, "They respect [family member's] decisions." They went on to explain, "I did join a six monthly review with [family member and the manager." We could see from records we reviewed that, where people had some difficulties expressing their preferences about their care, they could receive support from family members who knew them well.

People were supported to maintain contact with their friends and family and could have visitors at any time. One person told us, "The family comes in to visit; they can come in at any time." A relative said, "I don't tell them when I'm coming. I just turn up. It isn't a problem." Another relative explained, "I come every day and have done for the past four years. I'm always welcomed." We observed that relatives knew staff and interactions were relaxed and familiar.

Relatives told us how people were encouraged to bring in items such as small pieces of furniture or memorabilia. This helped people create a homely environment in their rooms and have some of their own, familiar belongings around them when they moved into the service.

Good

Is the service responsive?

Our findings

At our last inspection in August 2016, we found that the responsiveness of the service was good. At this inspection, we found that people continued to experience good outcomes in this area.

People's needs were properly assessed before they moved into the service so that staff knew the support people would need with their care. Where the local authority was involved in making placements, the management team also obtained information from them about people's needs. We noted that the registered manager had reviewed some placements made by predecessors, to ensure that people were receiving the right support. Where appropriate, they worked with others to ensure people's needs were met in alternative services.

Care plans provided guidance to staff about people's care and how they wished to be supported. They included information about people's personal care, health care, mobility and communication. They also prompted assessors and staff to consider any religious or cultural needs people may have. Care plans we reviewed had a one-page profile so staff could see at a glance what was important to the person and how best to support them. Staff had access to information about people's preferred routines, likes and dislikes.

Staff reviewed people's care plans regularly and made changes when people's care needs altered. A relative gave us an example of how staff responded well to a person's changed needs following an accident and what staff now did to assist them. Another relative told us how pleased they were with the support staff offered and which had enabled their family member to make progress. The relative said, "Within two months I saw an improvement in her mobility; within 6 months she was moving herself from her chair to her wheelchair." For another person who had not been sleeping well, a review of their needs led to an exploration of options to improve this for the person. A staff member explained to us that this had contributed to reducing the use of a medicine to help the person sleep. They told us how they had changed what they were doing with the person's routine having sought family advice about what the person did when they were at home.

Care plans also included information about people's personal histories. This supported staff to have conversations with people about things that were meaningful or important to them. For example, our discussions and observations showed that staff had good knowledge of one person's working life. We saw that the person took comfort, now they were living with dementia, in the presence of a doll, which reminded them of this. Staff understood the importance to the person of having the doll with them. Another person's record included how they preferred to be addressed, their hobbies and interests and information about people who were important to them. We saw staff addressing the person in the way described.

Staff told us that they felt they could generally take account of people's preferences, such as when they wanted to get up or go to bed, unless there were unexpected staff shortages. One staff member gave us a specific example about one person who liked to stay up late and chat with staff later in the evening. They told us that sometimes this meant they needed to take account of the person being tired and wanting to get up later in the morning.

A health professional told us that sometimes things might happen a little later in the day than usual, if there were staff shortages. However, they felt that staff did not cut corners when they delivered care if this happened. Staff spoken with were able to tell us about the support people needed, including with specific health conditions or mobility. The information they provided was consistent with what we saw within people's care records showing they understood how they needed to respond to meet people's needs.

During our inspection visits, some people were outside enjoying the garden. We saw staff assisted people to go out on outings, for walks, or to the dining room area to be able to participate in activities. In the Brookefields Unit, where people were living with dementia, the service had turned a small communal area into a "reminiscence lounge." This contained pictures, memorabilia and items from the past. A relative commented to us that their family member enjoyed spending time in this area.

The staff team, including maintenance person and activities coordinator, had worked to develop opportunities for people to engage in activities in the garden. One person told us about the raised flowerbeds. They said, "I like the flowerbeds, they are a better height for us. I am collecting the seeds so we can plant them next year. This is what I used to do in my own home." A relative told us that they had seen people using the raised beds when the weather allowed. This enabled people to spend time in the fresh air and pursue their previous interest in gardening if they wished to do so. We observed one staff member, walking arm in arm with a person at their own pace, preparing to go and water some of the plants.

All but one relative felt that there were activities people could engage in. Another person and their family member said they would like to see more opportunity for physical activity and exercise to help promote their wellbeing. Others were satisfied that there were things in place for them to enjoy, as were their relatives. For example, one relative told us, "There is always some form of activity for the residents going on, like reading or making pictures." One person told us how another person occasionally played the piano. We observed staff talking to people about books they were reading and reminiscing about the events they portrayed. One person did a jigsaw puzzle. Staff also spent time chatting with people.

One relative told us how their family member had their own copy of the programme of activities so that they could decide whether they wished to join in or not. They described how their family member did not like to join in very often but had really enjoyed a barbecue during the summer. They told us, "That was a real family event with staff children there. [Family member] doesn't come out of her room often but did for that, for two hours. It worked really well."

During the afternoon of our first inspection visit, a Pets as Therapy (PAT) dog came to the home. We saw that people enjoyed the opportunity to play with and fuss the dog. We saw that both the owner and a staff member guided the dog to people but checked first whether they liked dogs and wanted to engage with it. The staff member also engaged with people chatting about pets or animals they had owned in the past. People told us they enjoyed this. A hairdresser visited the home each month and records seen demonstrated people made use of this service.

There was an activities coordinator allocated to support people with their hobbies and interests for 25 hours each week. When they were not on duty, the registered manager expected care staff to engage with people to provider activities, based either on the plan or on people's choices on the day.
People, or their relatives, told us that they were confident they would be able to raise any concerns they had with the registered manager. For example, one person told us, "I have never had any concerns. If I did, I know who to talk to." One relative told us that normally things were resolved quickly and informally. They said, "The little things get sorted and get done." Another relative told us that they felt the way complaints were handled had improved under the current registered manager. They said, "I have had cause to

complain, at the time I felt it was being swept under the carpet… but [current registered manager] wouldn't. She treated me and the complaint with respect and responded promptly."

The registered manager maintained records of complaints received, together with the investigation and action taken. We noted that four complaints were logged since January 2017, one of which was about the management of bills and not the quality of care. Over the same period, there was a similar number of compliments. There was no pattern to indicate persistent and repeated failings in the service. We discussed with the management team that the complaints guidance displayed needed updating so that it was clear for people. This was because it did not refer to escalating the complaint within the provider's organisation if it was not resolved locally. It also did not refer to the role of the ombudsman in reviewing issues further.

Good

Is the service well-led?

Our findings

At our last inspection in August 2016, we found that the leadership of the service was good. At this inspection, we found that people continued to experience good outcomes in this area.

Staff understood their roles and the way they were expected to perform. We spoke with staff about the vision and values of the service. One told us they felt their role was, "To make people feel comfortable and look after them in a way you would want to be looked after yourself." Another staff member said, "Every single day is different. I learn things every day." They understood the risk that people could lose their independence and autonomy and the importance of spending time with people to encourage their independence. They recognised that people living with dementia needed additional time from staff and told us, "They [people] get that here."

Feedback from staff was that they felt they would be happy for a relative of theirs to be supported at Brooke House. A relative told us that they had also recommended the service and were satisfied with the quality of care.

Staff confirmed to us that the registered manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence. One staff member felt the registered manager was, "…a good leader and has time for everyone." We noted that the registered manager had changed office arrangements since taking over her role. The previous manager used a small office accessible through a staff office but not visible to people from the corridor. There was no window overlooking the front of the home to be alert for and to monitor visits and it was harder to hear what was going on in the home. The registered manager had moved from that room so that her desk was nearer to the main door and directly accessible from the corridor to staff, people and their relatives. The door remained open most of the time when the registered manager was using the office so that she could hear what was going on and offer support or intervene when she needed to.

A visiting professional told us they felt that the registered manager was approachable and showed concern for, and interest in, people's welfare. They told us they felt the registered manager was willing to go "… above and beyond…" her expected role to support people. They told us that they felt the registered manager was visible and accessible to the staff team and her willingness to help was good for staff morale. Staff confirmed to us that they felt morale and teamwork was good. A relative told us they had confidence in the approach of the registered manager and felt that she had a more constructive and open approach than they had experienced previously.

The operations manager and service quality manager had recognised the need to support the registered manager further in her role. She had considerable experience as a deputy manager before becoming registered manager and developed a sound understanding of the values of the service. The line managers for the service had plans to enhance management training further to develop skills for dealing with staff performance and with difficult situations.

There were meetings for people and their relatives to discuss their views and make suggestions for developing the service. We saw from notes of one of these that a particular change had been made in response to the suggestions, with the reintroduction of staff uniforms. One relative did raise with us that it would be nice to know the significance of the different colours of the tunics and how these related to staff roles. We discussed this with the management team as being easily remedied and enhancing clarity for people about who they were speaking to and whether it was the right person to address their comments.

All but one relative told us they felt informed about what was happening in the home. One said they had not attended any relatives meetings and did not feel that they were kept up to date with changes. However, we saw that information was recorded in minutes from meetings with people and their relatives, and available to them in the service. Other relatives were confident that were informed about their family member's welfare as well as being kept up to date with changes in the service. For example, one relative commented, "I think communication is better now between the care home and relatives than it was last year." Another told us, "I have attended the relatives' meeting where they discussed the introduction of the i-phones. The care home also put notices up to let the relatives know this is to record interactions and activity." They told us they were in support of new technology if it improved the individual care of the residents. They said, "I would say there has been an improvement in the detail of the care at the home. I think this is being driven in the recording of care on the i-phone the staff now carry."

We noted that the new technology had improved how staff categorised the logged the support that they provided. However, there were gaps in its use and, on occasions, a lack of consistent detail. The management team was aware of our concerns and assured us of the action they were taking to improve both the level of detail and how they monitored recording systems. We acknowledged that the system for keeping records of the support offered and of updating care plans had only been in operation for a few months before our inspection. Staff were still getting to grips with how it operated and changes needed time to embed. We also noted, and discussed with the operations manager, that the registered manager may need more support in 'interrogating' and accessing information through the computer. This would help the registered manager in the process of auditing and monitoring records to check how staff were using them.

The registered manager was aware of her responsibilities, including notifying the Care Quality Commission (CQC) of events taking place in the service. She acknowledged where there had been concerns about identifying and categorising events appropriately and followed them up. She had taken action to address gaps in the management team's knowledge and awareness by enrolling promptly in training. She also responded to our requests for additional information and evidence to help us evaluate the quality and safety of the service, after our inspection visits. This showed that they appreciated the legal requirement to cooperate with CQC.

The provider had complied with their legal obligations to display the rating given to them by CQC at their last full inspection, both within the home and on their website for Brooke House.

The registered manager was responsive to the feedback we gave following our first inspection visit about areas for improvement. She took action to make safeguarding referral identified as appropriate. Where we identified concerns for the quality of support at mealtime in the Brookefields Unit, she had already taken action before we returned for our second inspection visit. She had reminded staff of their roles and checked their competence to ensure they supported people properly and in a dignified manner so she could address any future performance issues. This had a positive impact in improving the quality of support people receiving during lunchtime on our second inspection visit. We were therefore confident, based on the prompt responses and development plans in place, that systems were effective in driving improvement.

We noted that the management team had responded to concerns that possibly, in their absence, systems for running shifts were not always well organised. They highlighted that there could be a "laid back" approach and standards were not properly monitored as expected. They were able to show us how they had addressed this with senior staff, clarifying responsibilities for running shifts and implementing a checklist for them to follow. They felt that this was working well to improve people's experiences and maintain standards as well as flagging up anything the management team might need to address.

There was a range of checks and audits on the quality and safety of the service, implemented by the registered manager with support from the operations and service quality managers. The operations manager and service quality manager also monitored whether the registered manager was completing internal audits, as she needed to for ensuring the service operated appropriately.